Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VICTOR KUMAR-MISIR, MD
1718 EAST HEDGECROFT DRIVE
SEABROOK, TEXAS 77586-5836

Respondent Name

STARBUCKS CORP

Carrier's Austin Representative Box

Box Number 48

MFDR Tracking Number

M4-09-A055-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have been unable to receive payment of the outstanding balance, and respectfully request your kind intervention on my behalf."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on July 6, 2009 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2009	99456-W5-WP	$300.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated NOT DATED

- W1 – WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Explanation of benefits NOT DATED

- W1 – WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- W1 – THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed the amount of $650.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and an IR was determined. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis are part of one body area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for the combined IR using Diagnosis Related Estimates (DRE) Category I method on the lumbar and DRE model on the pelvis-sacrococcygeal (one spinal region) is $150.00. The combined MAR for all of the MMI/IR services rendered is $500.00
2. The respondent has already reimbursed the amount of $350.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is entitled to additional reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 06, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.